		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER: 155152	A. BUI	LDING	01	01/04/2	
155152		B. WIN	_		01/04/20	012	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE MAIN ST		
MONTICELLO ASSISTED LIVING AND HEALTHCARE					CELLO, IN47960		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENC!)		DATE
K0000							
	A Life Safety Co	ode Recertification	K	0000			
	· · · · · · · · · · · · · · · · · · ·	sure Survey was			The creation and submission of thi Plan of Correction does not constit		
		he Indiana State			an admission by this provider of ar		
	Department of				conclusion set forth in the statement	nt of	
	•	h 42 CFR 483.70(a).			deficiencies, or of any violation of regulation.		
	accordance with	11 12 CIR 105.70(a).			-		
	Survey Date: 01/04/12 Facility Number: 000072 Provider Number: 155152						
					This provider respectfully requests	that	
					the 2567L Plan of Correction be		
					considered the Letter of Credible Allegation and requests a Desk Re	eview	
	AIM Number: 1				in lieu of a Post Certification Revie		
	And Itamber.	100207 110			or after February 3, 2012.		
	Surveyor: Bridget Brown, Life						
	Safety Code Spe						
	At this Life Safe	ety Code survey,					
	Monticello Assisted Living and						
	Healthcare was found not in						
	compliance wit	h Requirements for					
	Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection						
	Association (NF	PA) 101, Life Safety					
		apter 19, Existing					
		cupancies and 410					
	IAC 16.2.						
	· - -						
	This fully sprin	klered facility					
		one story building					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: THWH21 Facility ID: 000072 If continuation sheet Page 1 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152			LDING	01 (X3) DATE S COMPLE 01/04/20		ETED		
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN47960					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	of Type V (000) construction with a partial basement and a two story building determined to be Type V (111). The facility was surveyed as two buildings due to different construction types. The facility has a fire alarm system with smoke detection in the basement, corridors and spaces open to the corridors. The facility has a capacity for 147 residents and had a census of 94 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/06/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:							
K0044 SS=E	with 7.2.4. 19.2	.2.5	V	0044			02/03/2012	
	Based on obser interview, the f		I IX	7U 11	K 044		02/03/2012	
		ire door sets was tomatically close			It is the practice of this providensure that each fire door se			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155152 01/04/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1120 N MAIN ST MONTICELLO ASSISTED LIVING AND HEALTHCARE MONTICELLO, IN47960 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE arranged to close and latch each and latch. LSC 7.2.4.3.8 requires time they are released to close. fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the What corrective action(s) will Standard for fire Doors and Fire be accomplished for those Windows at 2-4.1.4 requires all residents found to have been closing mechanisms shall be affected by the deficient adjusted to overcome the practice? resistance of the latch mechanism so positive latching is achieved on each door operation. This The 1 West and 2 West fire door deficient practice affects visitors, sets have been adjusted and both sets close and latch each time staff and 41 residents on the 1 they are released to close. West and 2 West halls. Findings include: Based on observation with the How will you identify other maintenance director on 01/04/12 residents having the potential between 12:45 p.m. and 4:15 to be affected by the same deficient practice and what p.m., the 1 West and 2 West fire corrective action will be taken? door sets were tested twice manually and again upon activation of the fire alarm. One All residents have the potential to door in the fire door sets failed to be affected by the alleged latch each time the doors were deficient practice. released to close. The maintenance director All fire set doors have been released to ensure that they close acknowledged at the times of and latch. observation, the doors did not latch and said they did when the latch mechanisms were adjusted.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/04/2012			
	ROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN47960					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	3.1-19(b)		What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur?	into			
			A weekly test on fire doors heen added to the preventat maintenance weekly log. The Maintenance Supervisor or heesignee is responsible.	ive e			
			How the corrective action(s will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla	the ecur,			
			The preventative maintenand book will be reviewed during monthly CQI meeting by the Interdisciplinary team.	<u> </u>			
			Compliance Date: February 2012	3,			
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.						
	Based on observation and	K0046	K 046 It is the practice of th	is 02/03/2012			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

THWH21 Facility ID:

000072

If continuation sheet

Page 4 of 7

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152 NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN47960 (X5) PROVIDERS PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE)	
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE)	
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE)	
MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) (EACH DEFICIENCY MUST BE PERCEDED BY FULL) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI	
PREFIX CEACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CEACH CORRECTIVE ACTION SHOULD BE COMPLETE	
CROSS-REFERENCED TO THE APPROPRIATE	ON
THE REGULATOR OF ESCHELLING THE ORIGINATION)	
hattery operated emergency	
ensure 2 of 25 pattery powered lighting fixture operates as	
emergency lighting fixtures would required. What corrective	
operate. LSC 7.9.2.5 requires action(s) will be accomplished	
battery operated emergency lights for those residents found to	
shall be capable of repeated have been affected by the deficient practice? The 1	
automatic operation. This North and 2 North emergency	
deficient practice affects visitors, lighting fixtures have been tested	
staff and 32 residents on 1 North and the batteries have been	
and 2 North. replaced. Both fixtures are working properly. How will	
working properly. How will you identify other residents	
Findings include: having the potential to be	
affected by the same deficient	
Based on observation with the practice and what corrective	
maintenance director on 01/04/12 action will be taken? All regidents have the netertial to be	
between 12:45 p.m. and 4:25 residents have the potential to be affected by the alleged deficient	
p.m., the battery powered practice. All battery operated	
emergency lighting in the 1 North emergency lighting fixtures have	
ovit corridor and the 2 North	
working property. What	
lounge failed to illuminate when measures will be put into place tested twice. The maintenance or what systemic changes you	
director said at the times of will make to ensure that the	
deficient practice does not	
observation, these lights were recur? A monthly test of 30	
working when last tested and he seconds and an annual test of 90	
thought they might need new minutes will be conducted on all emergency lighting fixtures.	
batteries. emergency lighting fixtures. Batteries will be changed	
routinely and no less than once a	
3.1–19 (b) year. The Maintenance	
Supervisor or his designee will be responsible. How the	
corrective action(s) will be	
monitored to ensure the	
deficient practice will not recur,	
i.e., what quality assurance	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MUL ² A. BUILD! B. WING		O1	(X3) DATE S COMPLI 01/04/2 (ETED		
100102						01/04/20	712	
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
K0050 SS=F	Fire drills are held varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement manudible alarms. Based on recording the past 4 deficient praction occupants. Findings includes Based on a revirecords for the maintenance diat 1:05 p.m., fi were not found during the first quarters or the	at unexpected times under, at least quarterly on each familiar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2 dd review and acility failed to ed fire drills during quarters. This ce affects all e: ew of fire drill past year with the rector on 01/04/12 re drill records for the night shift	K00.		program will be put into pla The preventative maintenant log book will be reviewed dur the monthly CQI meeting by interdisciplinary team. Compliance Date: February 2012 K 050 It is the practice of this provider to ensure that fire drare held at unexpected times under varying conditions, at lequarterly on each shift. With corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A fire drill was performed on third shift. Fire drills are performed 1 per shift quarter utilizing each 2-hour is slot throughout each shift annually. How will you identify other residents have the potential to be affected by the	ce? nce ing the 73, is ills east nat en ft per time time the ce t	DATE 02/03/2012	
		rector confirmed at ord review, the fire			alleged deficient practice. Fire drills will be held at unexpected			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	(X2) MULT A. BUILDII B. WING		O1	(X3) DATE : COMPL 01/04/2(ETED	
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN47960					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ΓE	(X5) COMPLETION DATE	
	drills had not b				Maintenance Supervisor or h designee is responsible to er that the fire drill schedule is followed. The fire drill schedul includes a fire drill each quar each shift. The fire drill log b will be reviewed during the monthly CQI meeting by the	The is		